Some reflections on the development of child and adolescent psychiatry

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Remschmidt and Belfer have provided us with a very comprehensive survey of the main efforts that have been made in the last 20 years by various organizations to increase awareness of the children's emotional needs and promote their mental health. Still, one may wonder: why do we need so many advocates, laws, and conventions for children's rights? Why do some adults have to convince other adults that children have rights, including the one to be treated when emotionally ill? Why do we need to create systems whose main aim is to check that these conventions and laws are indeed applied, as if we suspected a priori that they will not?

Looking for an answer to these troubling questions, we suggest to reflect on the development of child and adolescent psychiatry, as a parallel process to the development of the perception that the adult society has of children. This has been quite a peculiar process: from the publication of Freud's case of Little Hans, it took more than 50 years to have a domain called child psychiatry. Adolescents were not perceived as different from adults, and the very notion that younger children have specific emotional needs was still very far away, in spite of the developmental psychopathological implications of Little Hans's case (obvious for us today). Then, in a slow and gradual process, triggered by the social revolution, adolescence was separated from adulthood, and researchers as well as writers started to study the specific normal and abnormal developmental paths of adolescence. The "discovery" of childhood depression was a major hallmark in the societal process of realizing that children can understand and feel, and therefore have a mental life. From then on, the domain of child psychiatry started to exist.

Then, again with a delay of 40 additional years, came the first publications and international meetings about developmental capacities of infants, demystifying the "tabula rasa" concept. Spitz's clinical observations on anaclitic depression in infants, and Bowlby's theory of attachment, published many years before, "suddenly" became relevant and helped to understand clinical states that existed all along, but had been ignored by the traditional medical community. From then on, an amazing bulk of studies on normal and pathological development of infants emerged and the domain of infant mental health was created.

Theoretical constructs change with the progress of knowledge, and nowadays more is known about continuities and discontinuities from infancy to adulthood through childhood and adolescence, due to longitudinal studies of attachment, temperament and various disorders in infancy. Continuity in psychopathology has been found much more common than expected, though the symptomatic expressions may differ according to the age and the child's developmental stage.

This amazing interplay between societal changes and scientific new knowledge should have been sufficient to convince health policy makers that resources must be allocated to the mental health care of infants, children and adolescents. However, as Remschmidt and Belfer have described, this is not the case, especially in some parts of the world, and in spite of numerous epidemiological studies. Therefore, we suggest looking for additional explanations for what we could name a "resistance".

We may identify two groups of societal factors: "political" and psychological. On the political side, parents' non-governmental organizations play a major role in lobbying, for instance, for autism, but not for anxiety disorders of childhood, nor psychoses. The result is a disproportionate allocation of resources to very specific disorders/conditions, regardless of epidemiology. In certain situations, decision makers may decide to allocate significant resources to post-traumatic stress disorder, again in a disproportionate manner, because they feel it is "politically correct". These priorities lead to increased research budgets for awareness and prevention of specific disorders, and none for others.

In parallel to these political factors, more subtle psychological variables may be at work. Some of the "difficult to convince" health policy makers may have "repressed" the child who is inside them, which may impinge on their ability for empathy and for reflecting on the children's needs.

Finally, we would suggest addressing not only the question of *what* should be done for improving our children's mental health, but also *where* this should be done. Indeed, one of the major settings where infant, child and adolescent psychiatry has developed is children hospitals. An increasing attention has been devoted to child and adolescent liaison psychiatry, and infant psychiatry has found its "natural" place in hospitals, because the main expressions of emotional distress at that age are somatic. Adolescent psychiatry is still mainly located in psychiatric hospitals, although there is a trend towards creating therapeutic boarding schools for adolescents. It is widely accepted today that child and adolescent psychiatry should be settled in the community, while keeping a certain number of beds in children hospitals and psychiatric hospitals. Nevertheless, this does not happen, in part due to a conflict between the patients' needs and the doctors' academic ones. Indeed, in most countries, academic positions require working at a university hospital. Consequently, the teachers themselves stay at the hospital, and cannot teach what they do not do, i.e. community psychiatry. As long as it is so, "community psychiatry" – which I do believe is the future of our discipline – will remain just a slogan.

Last but not least, related to our identity as child and adolescent psychiatrists, we are on the edge of two domains: pediatrics and psychiatry. In order not to be forced to answer the question "Whom do you love more, mom or daddy?", child psychiatry must remain an independent discipline with its own training program and research agenda.

Improving mental health care for children and adolescents: a role for prevention science

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Among all the topics raised by Remschmidt and Belfer, the most crucial might be their call to identify etiological factors to inform prevention programs. Modern prevention science is based on the concept of targeting or altering known risk factors or enhancing known protective factors that occur early in the chain of developmental events leading to disorder (1).

Primary prevention refers to any interventions that stop the onset of disease. They could block early environmental insults or mitigate the effects of genetic vulnerability. For example, improving the pre-, peri- and post-natal care of children born to families at risk for psychopathology might limit the impact of genes and spare children from the onset of disorders. They could also block later environmental insults in early childhood. For example, having identified a child at high risk for depression, we might use a family intervention program to help the family reduce stressors known to trigger depression. Secondary prevention does not prevent illness, but mitigates its course.

Prevention protocols distinguish two types of target populations. Selective preventive programs focus intervention resources on high risk children. For example, because young children with psychopathology are known to be at high risk for substance abuse in adolescence, they would be a logical group to use for a selective preventive program for substance abuse. In contrast to selective interventions, universal preventive programs apply prevention resources to all members of a designated population without regard to high risk status. Such programs are usually implemented in community settings such as schools.

Because universal programs target all children, they cannot be intensive or expensive and that constrains their efficacy. Yet some are clearly sensible, such as providing quality care to pregnant women. We have a limited ability to implement or design selective primary preventive interventions because we have yet to discover predictors that will allow us to identify with accuracy who will and will not become ill prior to the onset of a frank disorder. It is true that much research has validated statistically significant predictors of onset, but most of these are not sufficiently accurate to assure that the large majority of children selected for an intervention are truly at risk. Research aimed at discovering risk genes or neurodiagnostic measures of risk may provide accurate predictors in the future.

Mental health clinicians have the ability to implement selective secondary interventions but these are not routinely implemented. The potential for selective secondary intervention is clear in the treatment of psychosis. Wyatt's (2) review of twenty-one controlled studies found that schizophrenic patients who had been treated with antipsychotic medication during their first or second hospitalization had a better outcome than patients treated later. A more common example comes from the attention-deficit/hyperactivity disorder (ADHD) literature. ADHD children are at high risk for subsequent substance use disorders and a review of longitudinal studies showed that pharmacotherapy in childhood reduced the risk for substance use disorders in adolescence (3). As a general principle, treatment early in the course of a disorder should improve the outcome compared with treatment later in the course of illness, although we need more research to document the generalizability of this effect.

Clinicians can practice selective secondary prevention by using the well documented fact that children with one disorder are at high risk for having another (4,5). This suggests clinicians should periodically screen for psychiatric comorbidity and routinely educate parents about the potential for emergent disorders. Because effective parent-report instruments are available (6), such screening minimally burdens clinical resources. For example, given data suggesting that twenty to fifty percent of depressed youth will eventually have a manic episode (7,8), clinicians have a clear opportunity to identify and treat mania at its earliest stages.

Clinicians can avoid treatment delays by discarding unvalidated therapies and by using effective therapies in an efficient manner. When a survey asked American pediatricians what their first line treatment recommendation would be for a child with ADHD, 33% responded "counseling or psychotherapy" even though such treatment is known to be less effective than pharmacotherapy (9). This is an example of a widely held clinical belief that a less effective (and in some cases untested) psychosocial intervention should be the first line of treatment because it is safer than a more effective pharmacotherapy. But that logic breaks down when one considers the risks of delaying ineffective treatments. For mood disordered children, the risk could be suicide (the third leading cause of death among adolescents); for ADHD children it could be another year of falling behind in school (which makes subsequent years even more of an ordeal), and for any youth with psy-

chopathology it could mean an increasing cumulative burden of family stress and psychosocial disability (which complicates any subsequent treatment delivered after the less effective treatment fails). In the short time scale of childhood, delaying treatment can have massive effects on a child's development. If we delay effective treatment for two years when treating a mentally ill four year old, by the time the child is six, we will have exposed one-third of his life to the adverse impact of undertreated mental illness.

Remschmidt and Belfer provide a cogent and compelling rationale for societies worldwide to address the mental health needs of children and adolescents. Their health economic analysis and discussion of successful systems of care provide ample evidence that youth with psychopathology are underserved. One hopes that prevention science will become a top priority, when their call for action is heard, among the politicians and bureaucrats who plan the allocation of scarce resources, the mental health professionals who provide treatment, and the commercial interests that increasingly guide the development of novel pharmacotherapies.

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Developing modern child psychiatry

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It is a paradox that, in the second half of the 20th century, indicators of social wealth and physical health amongst children worldwide have improved, while mental health indices in young people have been deteriorating (1). Although there is still a lack of epidemiological data in developing countries about mental health problems in children, the bulk of the evidence suggests that one child or adolescent out of eight does suffer from mental health problems at any given point in time. It is also a paradox that very few of these children access mental health services in order to relieve their problems at a time where child psychiatry has developed new treatment approaches with demonstrated efficacy.

As pointed out in Remschmidt and Belfer's review, systems of care are needed in each country to deal with mental health issues of young people. These systems are unevenly developed worldwide, and unmet needs are substantial. The systems of care in developed countries have evolved through historical steps, with an initial concentration of psychiatric care in psychiatric institutions and the progressive development of child guidance clinics and outpatient programs and, more recently, more emphasis on community-based approaches. It is important to take this historical evolution into account and, for those countries which do not have systems of care currently in place, it would be a mistake to develop psychiatric services as they were developed elsewhere in the middle of the 20th century.

The philosophy of care, not only in psychiatry but in medicine at large, has changed, and emphasis is now placed onto quick access to care for patients irrespective of their geographical location or social or cultural position. The expertise of mental health professionals must follow the patients where they are rather than being concentrated in difficult to access expert centers. As this evolution in service delivery took place, the role of child psychiatrists has also changed. Child psychiatrists who, decades ago, were treating a small number of patients with play or family therapy for several months, now take on a consultant role for mental health professionals and other health professions in general. This means that child psychiatrists have a key role to play in devising health care delivery systems and that they must act in close partnership with other professionals, including nurses, general practitioners, family doctors, or pediatricians working in the community. Many of the evidence-based techniques to treat behavioural and emotional disorders can be delivered by other professionals than child psychiatrists, who will remain in insufficient numbers whatever happens in the next 20 years.

In improving access to care, the role of technology should be emphasized. Many countries have been struggling with systems of care which failed to deliver specialized services to distant regions with low population density. This is the case for Canada, Australia and many other countries worldwide. The development of telemedicine has been spectacular as a response to this difficulty and should be part of the planning of new systems of care in develop-

ing countries. Similarly, these techniques – or web-based approaches – can be used to facilitate the training of professionals in efficient and rapid format, also providing convenient means for ongoing supervision and consultations after the first training packages are administered.

Finally, it is true that advocacy is required and that professional organizations must lobby for the children's rights and for the promotion of child mental health by governments. Yet, the experience of many countries has shown that child psychiatry has developed when local leaders have emerged and played an influential role in their own country to promote mental health approaches. It is therefore important that international organizations as well as established academic centers worldwide follow a proactive approach to identifying training and mentoring investigators who might have the required leadership skills to impact on their systems of care efficiently.

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The future of child and adolescent mental health

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Remschmidt and Belfer provide a widely ranging, internationalist survey of mental health care for children and adolescents. The results are sobering. Despite the United Nations Convention on the Rights of the Child, epidemiological surveys of children's mental health and the burden of their problems, increasing knowledge of the principles of prevention, and advocacy for children by a number of international organizations, the Atlas survey by the World Health Organization reveals a worldwide paucity of specialized services, fragmented systems of care, and an absence of mental health policy for psychiatrically disturbed minors.

Why should this be so? In developing countries preoccupied with nutrition, water supplies, and infectious diseases, the answer is obvious. It is less clear in the more advanced countries of Europe, North America, Asia, and Australia.

Until the last 100 years, children's needs were not differentiated, and the problems of adults took precedence. Child psychiatry evolved from education, pediatrics, and adult psychiatry, often with difficulty. It is only in Europe that the profession has gained sufficient independence from its parent disciplines to be able to advocate for the needs of children. What should be done? Are any principles relevant worldwide? I recommend the following:

- Each country should press for a national mental health policy, with separate, specific recommendations for children.
- The policy should include sections on promotion, prevention, treatment, and monitoring (1).
- Mental health promotion requires attention to antenatal care, maternal mental health, infant and preschool language stimulation, and the avoidance or reversal of ethnic and social class discrimination.
- Prevention involves the elimination of risk factors and the enhancement of resilience by promoting social skills, learning, competence and a sense of efficacy. More needs to be known about the gene-environment interactions that lead to good and poor mental health.
- A minority of children with mental health problems receive any treatment. Even fewer receive specialized services. Advantaged countries must expand specialized services and extend their potential by educating primary care providers and incorporating them in systems of care.
- The cost-effectiveness of promotion, prevention and treatment should be monitored.
- Developing countries should decide how treatment could be implemented by their primary care clinicians, and seek help for training from developed countries.
- Public ignorance of and resistance to child mental health services must be addressed.
- Where impoverished countries are embroiled in war (internecine or otherwise), intervention is likely to be fruitless.

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Children's right to mental health. How adults have failed youth worldwide: the Latin America case

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Remschmidt and Belfer review the quality of mental health services for children and adolescents worldwide from the perspective of the children's rights. Not surprisingly, they point out the lack of data to assess quality of services in the areas of the world, such as Africa and Latin America, where these

systems need more revision and where the violation of children's rights is likely to be more pervasive.

Children have rights, and among them, the right to health care. However, the blatant violation of children's rights in developing as well as industrialized countries worldwide is common knowledge. The very individuals expected to protect minors are frequently the main culprits in this unfortunate global tragedy, perpetuating mental and physical disorders in this population and creating the conditions for further violation of human rights. Juvenile judicial systems, health care agencies, the entertainment industry, the media, politicians, professionals, the church and even parents across the world are all-too-commonly implicated in the practice of innumerable forms of violence directed against minors, such as severe corporal punishment (including judicial and extra-judicial execution), illegal adoptions, sexual abuse (including child pornography and prostitution), and their exploitation through child labor or as fighters in armed conflicts (1). The global panorama in these regards is appalling.

It is true that the Convention on the Rights of the Child is the most widely ratified rights treaty in history, as only two countries, the United States and Somalia, have not ratified it (2). The Convention sets standards in health care, education and legal, civil and social services. Unfortunately, from theory to fact there is a big gap, and true implementation of the actions and policies to reach standards and benchmarks articulated in the Convention remains at best incomplete in most countries.

In Latin America, most children live in poverty and face numerous risk factors leading to mental illness, such as family disruption, social unrest, drug trafficking, criminality, and natural disasters (3,4). The prevalence of mental disorders is similar to the 15% to 20% found in other areas of the world; in contrast, very few are identified by primary care practitioners, and even fewer receive appropriate treatment (5). Furthermore, on average, national health expenditure is significantly lower than in the developed world (4), and, although data are certainly incomplete, mental health services for children are clearly underdeveloped in most Latin American countries (6).

Factors contributing to this tragedy are varied and go from scarcity of funding to poor education about mental health issues in the target population. But let us not fool ourselves. The main cause lies in the lack of commitment on the part of the national and global entities entrusted with the responsibility to develop effective national and regional policies and plans for child mental health programs (6). This creates a vicious cycle that goes from lack of services to lack of diagnosis, treatment and prevention, to lack of appropriate data to inform planners and policy makers. Until that cycle gets broken by a serious and well coordinated global effort from institutions such as the World Psychiatric Association, the World Health Organization and its regional branches, local ministries of health and non-governmental organizations concerned with the wellbeing of children, the tragedy children live today concerning mental health will go on forever.

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Mental health care for children and adolescents: a regional perspective

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Nowadays, the whole world is in a flux of transformations in social structures, cultural values and behavioral patterns. People move around the world, migrate and return, live abroad and raise children abroad. They are bound to live together with other ethnic and cultural groups, and to get in touch with different cultural orientations and values. "Cultural invasions", cultural pluralism and clashes between cultures are inevitable consequences. New crises or an intensification of the existing crisis in child rearing and child mental health can be expected.

Conflicts between cultures occur not only at the international level, but also within a country or even within each individual. Globalization in economies, politics and cultures and the consequent clash of civilizations demand a global ethics and a new way to coexist. Likewise, we, child mental health professionals, are forced to think of mental health in a global perspective and to acknowledge the need for developing effective preventive and therapeutic interventions on a global scale.

In this context, the paper by Remschmidt and Belfer is timely and extremely relevant in providing data on the current status of child mental health care and advocating for the development of child mental health services worldwide. It is remarkably rewarding to see recent efforts of the World Psychiatric Association, the International Association for Child and Adolescent Psychiatry and

Allied Professions, and the World Health Organization in emphasizing the crucial importance of mental health care for children and adolescents.

More than 50% of the countries in the world lack any formal child psychiatric service, and only a few countries have established a successful service system. In order to start a child mental health service program in any country, it is essential to secure qualified child psychiatrists who will be the pioneers for the development of child psychiatry. Training people abroad, e.g. in the USA or the UK, is very consuming in time and money. It is also limited in terms of the number of trainees and the contents of training, which may not be culturally appropriate. Therefore, I would like to propose that regional training centers for child psychiatry/child mental health be established in all regions of the world (e.g., one or two centers in Asia, Africa, South America). International societies, such as the International Association for Child and Adolescent Psychiatry and Allied Professions, could help the regional centers by providing lecturers and faculties.

It should be pointed out here that most of the international meetings in our field seem to be geared toward spearheading rigorous scientific research projects and downplaying clinical research projects in the countries where child psychiatry has just been established. Psychosocial research carried out in developing countries is often disregarded and rejected, and sophisticated biological research conducted in developed countries is given priority, because the former is considered "sloppy, not enough empirical". If any scientific organization wants to be truly international, it will have to take into account that most non-Western countries are still at varying stages and degrees of scientific sophistication. International meetings and journals should not be designed only for Western developed countries. We should also reevaluate the relevance of training psychiatrists from non-Western developing countries at the training institutions of Western countries. Cultural sensitivity, cultural relevance and cross-cultural issues should be emphasized as part of training abroad. The curriculum should include the social and cultural changes due to modernization and their impact on mental health, cross-cultural psychiatry, anthropology and ethnology.

I would like to make a plea that the leading international organizations like the World Health Organization, the International Association for Child and Adolescent Psychiatry and Allied Professions and the World Psychiatric Association should continue their efforts and take necessary actions to assist the establishment of child psychiatry/child mental health services in developing/underdeveloped countries, and that international scientific meetings should allocate time to discuss the issues involved in establishing child psychiatry services and the clinical problems of developing countries which do not have adequate child mental health/child psychiatry services.

Mental health care for children: the needs of African countries

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There is a crying need for developed countries and non-governmental agencies based in those countries to assist developing countries with the training of personnel like child psychiatrists, psychologists, and psychiatric nurses interested in the treatment of psychologically and mentally handicapped children. The few child psychiatrists available to meet the needs of huge numbers of children and adolescents in need of treatment are at the moment "jack of all trades" in all aspects of mental health care. The thrust of services as brilliantly articulated in Remschmidt and Belfer's paper for Europe and North America, while generally seen as heuristic, is still largely a dream in Africa and may remain so for several years to come.

While dearth of personnel and services are crying for attention, it is generally agreed that preoccupation of families is still the *survival* of children. When psychological, general developmental and learning or coping difficulties appear, there is very little action organized in a purpose-oriented manner in many parts of Africa. The development of health and allied social services rank very low in African governments priorities, as this aspect of services competes with provision of infrastructural and other social services such as roads, portable water, light, food, education, housing, communication, etc.

Children from educated or "affluent" homes do get seen by health workers, e.g. psychiatrists, general and specialist doctors. Very little is known about the real outcome of these contacts, because such programmes are poorly organized, neither are they sustainable.

Meagre and unquantifiable as services for children and adolescents in many parts of Africa may be, a programme of training seminars for mental health personnel organized by the World Psychiatric Association would be extremely useful for sub-Saharan Africa countries. Apart from the real possibility of such an initiative being a launching pad for pragmatic approach by such health professionals presently available in the sub-region, such seminars could result in a meaningful and worthwhile impact on African governments, in particular where lack of programme development is due to lack of political will.

Intervention in child abuse and neglect: an emerging subspecialty in child and adolescent psychiatry

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Remschmidt and Belfer rightly point out the importance of developing rights-based and evidence-based policies for dealing with child and adolescent mental health problems. Awareness, prevention and intervention are especially required, and achievable, in the area of child abuse and neglect (CAN).

All types of CAN can produce short- and long-term psychological sequelae. "Abused children have learned that their world is an unpredictable, often hurtful place. The adults who care for them may be angry, impatient, depressed, and distant. Further, they can be transformed without warning into hostile, violent persons" (1). The young child may feel incompetent, unlovable, helpless and powerless, and become suspicious of others. Older children often demonstrate emotional problems, such as depression and anxiety. Verbally and physically aggressive behavior as well as passive compliance and avoidant behavior have been reported. Physically abused children frequently have significant problems in their ability to develop and sustain peer relationships (2). A history of sexual abuse may contribute to becoming a sexual offender (3,4).

In contrast to physical and sexual abuse (where children experience visibility, albeit negative), the neglected child feels invisible. Neglected children have been shown to become helpless and passive, and to display less affect, either positive or negative, in their peer encounters (5).

A systematic review has shown that both male and female victims of abuse have significantly higher rates of psychiatric treatment than the general population (6). Accordingly, it is essential for psychiatrists to consider a history of childhood abuse in their patients, and be familiar with the definitions, dynamics, and effects of all forms of CAN. Child and adolescent psychiatrists must also be able to work with parents and families. The complexity of CAN cases make it a necessity that psychiatrists cooperate not only with nurses, pediatricians, psychologists, psychotherapists and clinical social workers, but also with child protection workers, criminal justice professionals and the judiciary.

The realization that CAN is relevant to a variety of child, adolescent, and adult mental health problems, and the dramatic increase in cases, have created a need for clinical specialization with child victims and adult survivors of CAN. The Physical Abuse Assessment Model, the Physical Abuse Process Therapy Worksheet (7) and the "abuse-focused therapy" are examples of efforts aimed at meeting this need. Moreover, recent years have witnessed the emergence of national, regional and international professional associations based on a multidisciplinary membership of mental health, social work, medical and criminal justice professionals and the judiciary. A main international example is the International Society for the Prevention of Child Abuse and Neglect (ISPCAN) and its regional partner networks such as the Network of Arab Professionals for the Prevention of Child Abuse and Neglect. Professional journals, e.g. the ISPCAN Journal, that specifically focus on CAN are another important development, because they keep the field updated on new research.

CAN intervention as a subspecialty in child and adolescent psychiatry is feasible, and could be encouraged if basic and advanced training were offered in undergraduate and graduate level courses, and if courses on CAN were required for those applying for license renewal.

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